New Patient Back Intake Packet

Demographics and Insurance Confirmation

Please review the information below and notify the front desk of any corrections.

Patient Name: _____
Date of Birth: _____

Address: _____

Home Phone: _____ **Mobile Phone:** _____
Email: _____

Emergency Contact Name and Mobile Phone: _____

Primary Insurance: _____
Member ID: _____
Group Number: _____

Secondary Insurance: _____
Member ID: _____
Group Number: _____

☐ I confirm that the demographic and insurance information above is correct.
☐ I have provided corrections to the front desk.

Patient/Responsible Party Initials: _____

Medical History

1. Current Medications

List all prescription medications, over-the-counter medicines, and supplements you take. ☐ None

Medication Name	Dose	How Often

2. Allergies

Include medication, latex, and contrast/dye allergies. ☐ None

Allergy (Medication or Substance)	Reaction

3. Prior Surgeries and Procedures

List any operations you have had, including spine, joint, heart, or other procedures. ☐ None

Surgery or Procedure	Approximate Year

Preferred Pharmacy (Name and City): _____

Patient Signature: _____ Date: _____

Numeric Rating Scale (NRS) Pain Assessment

Where is your primary pain today? _____

Pain Score Today

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

No Pain **Mild** **Moderate** **Severe**

Pain Rating	**Score**	**Pain Location**
Pain now	____ / 10	_____
Best pain in past week	____ / 10	_____
Worst pain in past week	____ / 10	_____
Average pain in past week	____ / 10	_____

Does pain travel into an arm or leg?

☐ No ☐ Yes

If yes, where?

Does pain interfere with sleep, work, walking, or daily activities?

☐ No ☐ Yes

Oswestry Disability Index — Back (ODI-B)

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Instructions: This questionnaire is designed to evaluate how back and leg pain affect everyday life. Select **one** statement in each section that most closely describes your present-day situation.

Section 1 — Pain Intensity

☐ I can tolerate the pain without having to use painkillers
☐ The pain is bad but I can manage without taking painkillers
☐ Painkillers give complete relief from pain
☐ Painkillers give moderate relief from pain
☐ Painkillers give very little relief from pain
☐ Painkillers have no effect on the pain and I do not use them

Section 2 — Personal Care (Washing, Dressing, etc)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally, but it causes extra pain.
☐ It is painful to look after myself, and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self-care.
☐ I do not get dressed. I wash with difficulty and stay in bed.

Section 3 — Lifting

☐ I can lift heavy weights without causing extra pain.
☐ I can lift heavy weights, but it gives me extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

Section 4 — Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile
☐ Pain prevents me from walking more than one-half mile
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 — Sitting

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than one hour.
☐ Pain prevents me from sitting for more than 30 minutes.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Section 6 — Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want, but it gives me extra pain.
☐ Pain prevents me from standing for more than one hour.
☐ Pain prevents me from standing for more than 30 minutes.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 — Sleeping

☐ My sleep is never disturbed by pain.
☐ My sleep is occasionally disturbed by pain.
☐ Because of pain, I have less than 6 hours of sleep.
☐ Because of pain, I have less than 4 hours of sleep.
☐ Because of pain, I have less than 2 hours of sleep.
☐ Pain prevents me from sleeping at all.

Section 8 — Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life, and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 — Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere, but it gives me extra pain.
☐ Pain is bad, but I manage journeys over 2 hours.
☐ Pain restricts me to journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 — Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

For Office Use Only
Total Score: _____ / 50
Disability Percentage: _____ %
Staff Initials: _____

EQ-5D-5L Health Questionnaire

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Instructions: Under each heading, select the one statement that best describes your health **today**.

Mobility

☐ I have no problems walking about.
☐ I have slight problems walking about.
☐ I have moderate problems walking about.
☐ I have severe problems walking about.
☐ I am unable to walk about.

Self-Care

☐ I have no problems washing or dressing myself.
☐ I have slight problems washing or dressing myself.
☐ I have moderate problems washing or dressing myself.
☐ I have severe problems washing or dressing myself.
☐ I am unable to wash or dress myself.

Usual Activities

☐ I have no problems doing my usual activities.
☐ I have slight problems doing my usual activities.
☐ I have moderate problems doing my usual activities.
☐ I have severe problems doing my usual activities.
☐ I am unable to do my usual activities.

Pain / Discomfort

☐ I have no pain or discomfort.
☐ I have slight pain or discomfort.
☐ I have moderate pain or discomfort.
☐ I have severe pain or discomfort.
☐ I have extreme pain or discomfort.

Anxiety / Depression

☐ I am not anxious or depressed.
☐ I am slightly anxious or depressed.
☐ I am moderately anxious or depressed.
☐ I am severely anxious or depressed.
☐ I am extremely anxious or depressed.

For Office Use Only
Health State: _____
Total Score: _____
Staff Initials: _____

Patient Health Questionnaire-4 (PHQ-9)

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Check one box on each line.

	Not at all **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING 0 + _____ + _____ + _____ =

Total Score: ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Brief Spine Review of Systems

Please check all symptoms you are currently experiencing or have recently experienced.

Constitutional Symptoms

☐ Fever
☐ Hot Flashes
☐ Weight Loss
☐ Chills
☐ Night Sweats

Respiratory

☐ Trouble Breathing
☐ Shortness of Breath
☐ Sleep Apnea
☐ Wheezing

Cardiovascular

☐ Chest Pain
☐ Limb Pain on Walking
☐ Limb Swelling
☐ Pedal Edema

Musculoskeletal

☐ Muscle Pain
☐ Muscle Twitches
☐ Neck Pain
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Cramp
☐ Loss of Muscle Bulk
☐ Back Pain
☐ Joint Stiffness

Neurological

☐ Seizures
☐ Blackouts
☐ Headache
☐ Numbness
☐ Weakness
☐ Tremors

Other symptoms or concerns:

HIPAA Authorization Form for Family Members/Friends

I _____, give permission to all my health care and medical service providers and payers to disclose and release my protected health information described below to:

Name(s), Relationship and Phone #: _____

_____

_____

Health Information to be disclosed (check all that apply):

☐ My complete Health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

OR

☐ My Complete Health Record, as above, with the exception of the following information:

- ☐ Mental Health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This Authorization shall be effective until (check one):

☐ All past, present and future periods

OR

☐ Date or event: _____ unless I revoke it.

Note: You may revoke this authorization at any time by notifying your healthcare providers, preferably in writing.

Patient Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Financial Responsibility Agreement

General Policy

SSMI PLLC provides medical services that may be rendered on a self-pay basis or billed to insurance carriers depending on the nature of the services provided, the site of care, and applicable requirements. Professional services provided by SSMI PLLC are billed separately from facility, anesthesia, imaging, laboratory, or other third-party services, which may be billed independently by those providers.

Patient Responsibility

I understand that financial responsibility may include copayments, deductibles, coinsurance, non-covered services, or self-pay fees, depending on the circumstances of my care. Whenever feasible, SSMI PLLC will review anticipated financial responsibility prior to services being provided; however, I understand that final responsibility is determined by the services rendered and applicable coverage.

Insurance Information

I understand that insurance verification or benefit information does not constitute a guarantee of coverage or payment. While SSMI PLLC may assist with insurance billing when applicable, I remain responsible for understanding my insurance benefits, limitations, and financial obligations. I understand that some services may not be covered by my insurance plan or may be subject to out-of-network benefits or federal and state patient protection laws, depending on the circumstances and site of care. I understand that certain services may be subject to federal and state balance billing protections, including the No Surprises Act. When applicable, these laws limit my responsibility for certain out-of-network charges and provide dispute resolution protections. I understand that SSMI PLLC will comply with applicable patient protection laws and that additional disclosures may be provided when required.

Site of Care

I understand that services may be provided in different settings, including clinic, hospital, ambulatory surgery center, or via telemedicine, and that billing and financial responsibility may vary based on the site of care.

Assignment of Benefits and Insurance Authorization

I hereby assign all medical benefits, including major medical benefits, to which I am entitled to SSMI PLLC. I authorize and direct my insurance carrier(s) to issue payment directly to SSMI PLLC for services rendered to me or my dependent(s). I authorize SSMI PLLC to submit claims to my insurance carrier(s) on my behalf and to appeal any denied or partially paid claims. I authorize SSMI PLLC to release any medical information necessary to process insurance claims, obtain payment, and conduct healthcare operations. I understand that I may be financially responsible for charges not covered or paid by my insurance, subject to applicable federal and state laws.

In the event my insurance carrier pays me directly for services rendered by SSMI PLLC, I agree to forward the payment to SSMI PLLC immediately upon receipt. I understand that if my insurance carrier denies payment or only partially pays for services, I am responsible for the remaining balance. I agree to pay all copayments, deductibles, coinsurance, and non-covered services at the time of service or upon receipt of a statement from SSMI PLLC.

Electronic Communications and Signatures

I authorize SSMI PLLC to communicate with me electronically, including through patient portals, email, text messaging, and telemedicine platforms, as permitted by law.

I understand and agree that my electronic signature on this document is the legal equivalent of my handwritten signature and is binding for all purposes.

I consent to receiving care via telemedicine when deemed appropriate by my provider and understand that the same standards of privacy and confidentiality apply. I understand that I may decline or discontinue telemedicine services at any time.

Notice of Privacy Practices (HIPAA)

I acknowledge that I have been provided access to the Practice's Notice of Privacy Practices, which describes how my protected health information may be used and disclosed and explains my rights with respect to that information. I understand that I may request a paper or electronic copy of the Notice of Privacy Practices at any time.

Authorization for Release of Medical Records

I authorize SSMI PLLC and its physicians to request, obtain, review, and use my medical records, diagnostic imaging, laboratory results, and other protected health information from any and all healthcare providers, facilities, and third parties as necessary for the evaluation, diagnosis, and treatment of my medical condition. This authorization includes, but is not limited to, records from physicians, hospitals, imaging centers, laboratories, pharmacies, physical therapists, and other healthcare providers who have provided care to me.

I further authorize SSMI PLLC to disclose my protected health information to other healthcare providers, facilities, insurance carriers, legal representatives, and other parties as necessary for my care, payment processing, healthcare operations, legal requirements, or as otherwise permitted or required by law.

I understand that I have the right to revoke this authorization at any time by providing written notice to the Practice, except to the extent that action has already been taken in reliance on this authorization.

Questions and Assistance

I understand that SSMI PLLC's billing team is available to answer questions regarding fees, anticipated financial responsibility, and payment options when applicable.

Patient Acknowledgment

By signing below, I acknowledge that I have read, understand, and agree to the terms of this document, including the Consent to Treat, Telemedicine Consent, Notice of Privacy Practices acknowledgment, Authorization for Release of Medical Records, Financial Responsibility Agreement, and Assignment of Benefits and Insurance Authorization.

Patient Name (Print): _____

Patient Signature: _____ **Date:** _____

Legal Guardian / Authorized Representative (if applicable): _____

Signature: _____ **Date:** _____